TEXAS Department of State Health Services

Form 112

COUNTY INDIGENT HEALTH CARE PROGRAM
SSI APPELLANT NOTIFICATION

CHECK ONE: ☐ **NON-PRESCRIPTION SERVICES** ☐ **PRESCRIPTION DRUGS**

Appellant's Name	Sex	Date of Birth	Social Security Number

Provider's Name	Medicaid Billing ID No. (National Provider Identifier – NPI)	Date Provider Signed Form 113

Date County Wrote Check to Pay the Bill	Date of Service	Amount Billed	Amount Paid	For DSHS Use Only
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
Total Paid to Provider			$	

(Attach additional forms for this provider and this appellant if necessary.)

In filing this claim, the undersigned certifies that (1) the information listed above and on all attached sheets represent the true amounts this county paid for all Medicaid-covered services provided to this SSI appellant for whom Medicaid reimbursement is claimed and (2) s/he understands all reimbursements made by DSHS to the county for CIHCP services provided to the above-named appellant are subject to HHSC post-pay audits.

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Signature of the County Judge/Designee **Date**

Name of County Judge/Designee	County	Telephone Number
		( )
Address (Street, City, ZIP)		

This form is used only if the county is filing for Texas Medicaid reimbursement through DSHS.

PURPOSE

- To certify the county paid the claims listed and
- To claim Medicaid reimbursement for claims paid for CIHCP basic or some department-approved optional health care services provided by Texas Title XIX-enrolled providers.

Claims must be received by the CIHCG in Austin within 95 days of the Medicaid "add date," which is the date the appellant's Medicaid eligibility is added to the computer system.

PROCEDURE

For the case record of each appellant who is determined retroactively eligible for Medicaid,

1. Separate claims into non-prescription services and prescription drugs.
2. Separate non-prescription claims by provider.
3. Separate prescription drug claims by provider.
4. Complete a separate Form 112 for each provider.

Make additional copies of Form 112, as necessary.

DETAILED INSTRUCTIONS

Check the appropriate box at the top of Form 112 to indicate whether the claim is for non-prescription services or for prescription drugs.

Complete the information about the appellant.

Complete the information about the provider.

List the amount paid for each claim on separate lines and in order by the Date of Service.

The county judge/designee must sign and date the certification at the bottom of each Form 112 submitted.

The county must complete the information about the county judge/designee at the bottom of Form 112.

To each Form 112, attach:

- The corresponding claims and
- One copy of the completed Form 113, Appellant/Provider Assignment.

FORM RETENTION

Maintain one copy of each completed Form 112 and all attachments at least until the end of the third complete state fiscal year following the date on which the reimbursement is received.